2002 Iowa School Health Education Profile

HIV/AIDS Education Project, Iowa Department of Education . . . . . February 2003

ADMINISTRATIVE SUMMARY SHEET

The Iowa Department of Education HIV/AIDS Education Program, through a cooperative agreement with the Division of Adolescent and School Health (DASH), National Center for Chronic Disease Prevention and Health Promotion, U.S. Centers for Disease Control and Prevention (CDC), provides assistance to schools and other youth service agencies to strengthen comprehensive school health education to prevent human immunodeficiency virus (HIV) infection, other sexually transmitted diseases (STDs), and promote healthy behaviors and attitudes. The School Health Education Profile (SHEP) includes two questionnaires, one for school principals and one for lead health education teachers. The questionnaires were developed by the DASH/CDC in collaboration with representatives of 75 state, local, and territorial departments of education.

Methodology

The questionnaires were mailed to a random sample of 347 secondary schools containing any of grades 6 through 12 in Iowa during the spring of 2002. One school was ruled ineligible. Usable data were received from 263 out of the 346 eligible sampled principals, which yielded a response rate of 76.0%. Usable data were received from 262 out of 346 eligible sampled lead health education teachers, which yielded a response rate of 75.7%. Both of these response rates were judged sufficient by the CDC for "weighting" the data and making inferences about the populations of *all* principals and lead health education teachers in Iowa in 2002. These rates were slightly higher than the projected rates of 75%, so the sample sizes were slightly above those required for the established margin of error (5%) and level of confidence (95%).

The data are summarized in a final report, prepared for the Iowa Department of Education. This report is available upon request. (See "Note" below.)

Discussion: Selected Results from the 2002 Iowa SHEP

In the discussion that follows, we consider three critical areas of health education: (1) HIV and other STDs; (2) violent juvenile crime; and (3) tobacco use. Selected results from the 2002 Iowa SHEP are presented relating to these areas.

1. HIV and Other STDs: Policy, Student Behavior, and Preventive Health Education

Sixty-five percent of principals indicated that their schools have adopted a written policy that protects the rights of students or staff with HIV infection or AIDS. This was a substantial increase over the percent who indicated they had adopted such a policy in the 2000 SHEP (49%).

According to the 1997 Iowa Youth Risk Behavior Survey (YRBS) including 1,521 high school students from across the state, 27% of 9th graders, 39% of 10th graders, 50% of 11th graders, and 58% of 12th graders indicated that they had engaged in sexual intercourse. Slightly over one-fifth of them indicated that they had four or more sexual partners (in their life) by the 12th grade. These percentages were close to those reported in 1998 by the CDC for the nation as a whole. In the 1997 Iowa study,[1] among students who said they had intercourse during the three months prior to taking the survey, only about 48% said they or their partner had used a condom to prevent sexually transmitted diseases. Nationally, according to a 1998 CDC report, female students in grade 12 were significantly less likely to report using a condom during last intercourse than were female students in grades 9 or 11.

Engaging in sexual intercourse, especially if protection is not used, puts students at risk of being infected with HIV and other STDs. *Yet, during their senior year in a high school—when reported incidence of sexual intercourse was highest and reported condom use was lowest—only 32% of students received required health education (compared with 69% in grade 7 and 65% in grade 9) in Iowa in 2002.*

Most lead health education teachers in Iowa (98%) tried to increase student knowledge of HIV in required health education courses in 2002. Specifically, 97% taught abstinence as the most effective way to avoid HIV infection, but only 44% taught how to correctly use a condom—as part of required health education.

2. Violent Juvenile Crime and Violence Prevention Activities

There is evidence that violent juvenile crime and delinquency are increasing in Iowa. For example, the number of delinquency petitions filed increased from 4,975 in 1992 to 6,610 in 2001. It is projected that this figure will increase to around 7,000 in 2002 (Jerry Beatty, Judicial Branch, State of Iowa, personal communication, February 7, 2003). Teenage gang activity and gang-related crime have also increased in Iowa since the late 1980s. These are *health problems*, as well as social problems.

The challenges to those working in education, health care, juvenile justice, and human services are to (1) develop effective methods for reducing this problem and (2) ensure the provision of care for its victims. There is evidence from this profile that at least the first of these challenges is being met in the schools in Iowa. Seventy-nine percent of lead health education teachers in Iowa reported that they attempted to improve student knowledge in the area of violence prevention

[1] This was the most recent YRBS in Iowa that provided weighted results—generalizable to all senior high school students in the state. The 2003 survey is currently being conducted.

in 2002. Moreover, the skill of nonviolent conflict resolution was taught in 78% of schools in Iowa in 2002. Finally, there is evidence that many schools in Iowa have put security measures in place, such as requiring visitors to report to the main office or reception area, using staff or adult volunteers to monitor halls, and maintaining a "closed campus."

3. Tobacco Use Policy and Prevention Education

According to the Iowa Department of Education's *Iowa Youth Survey* cited in a 1997 report by the Governor's Alliance on Substance Abuse, self-reported cigarette smoking (two or more times per week) increased among Iowa youth from 1981, nearly doubling for students in grades 6, 8, 10, and 12 to 13% overall in 1996. According to the 1997 Iowa YRBS, 37.5% of high school students reported smoking cigarettes at least once in the month prior to the survey, while 12.8% reported using smokeless tobacco during this same period.

There is evidence from this profile that schools are making an effort to control, reduce, and prevent tobacco use. It was estimated that nearly all (99%) of principals in secondary schools in Iowa have adopted a policy prohibiting cigarette smoking by students. In most cases, this applied to all school buildings, school grounds, school buses, and school events. The most common actions taken when students are caught smoking cigarettes are to (1) refer the student to a school administrator and (2) inform the student's parent(s) or guardian(s) about her/his smoking. Policy specifically prohibiting students from using smokeless tobacco, cigars, and/or pipes was also reported by more than 90% of the principals. Most principals (over 90%) reported that tobacco advertising is prohibited in their schools, as is the wearing of tobacco name-brand apparel and the carrying of tobacco name-brand merchandise. Finally, 46% of principals indicated that their school had posted signs marking a tobacco-free school zone (up from 28% in the 2000 SHEP).

In terms of education, it was estimated that 98% of lead health education teachers in Iowa in 2002 tried to increase student knowledge in the area of tobacco use prevention. Moreover, more than 90% of these teachers indicated that the following specific tobacco use prevention topics were taught in required health education courses in their schools: short- and long-term consequences of cigarette smoking and use of smokeless tobacco, benefits of not using cigarettes or smokeless tobacco, addictive effects of nicotine, number of young people using tobacco, number of deaths and illnesses related to tobacco use, the influence of the media on tobacco use, how to say no to tobacco use, and the effects of second-hand smoke. Fifty-one percent of health education teachers indicated they would like to receive training in tobacco use prevention; only 27% said they had received such training in the past two years.

Recommendations: Health Education in Iowa and the SHEP

- *Encourage additional HIV prevention training or reinforcement of earlier training for juniors and seniors in high school.*

Required health education courses should be delivered to more juniors and seniors, who are most at-risk of HIV infection because of their sexual activity. This should include skills for prevention of HIV and other STDs (e.g., correct use of condoms) as well as knowledge of HIV prevention (e.g., condom efficacy).

- *Encourage the cooperation and collaboration among the components of the support system for the delivery of health education to students in Iowa schools.*

Components of this system include local entities such as the school administration, parents, adult volunteers (e.g., mentors), community-based agencies, and the business community. Other components might include the Area Education Agency and state and federal government agencies, such as the HIV/AIDS Education Project in Iowa and the CDC. An example of where cooperation and collaboration are needed is the development of health advisory councils. Only 39% of schools in Iowa in 2002 had an active health education advisory council or similar committee, according to school principals. Another example of cooperation and collaboration is in the use of peer educators, reported by 51% of the lead health education teachers in Iowa in 2002. Programs should capitalize on the fact that kids talk to other kids and utilize *positive* peer pressure to change their behavior. Collaboration is a key to making such programs work.

- *Use violence prevention training (for students and teachers) more extensively to counter increases in violent juvenile crime and delinquency.*

In particular, more emphasis should be given to teaching violence prevention *skills* to increase healthy behaviors among our youth. These include the development of de-escalation, mediation, and conflict resolution skills through role-playing, as well as a planned process for whole school discipline and safety (Dr. Lee Halverson, Consultant at Heartland Area Education Agency, personal communication, November 29, 1995). This may need to begin at the elementary level. An example of such a program is the Woodbury Drug and Violence Prevention Program in Marshalltown, which was cited by the Iowa Department of Public Health for "best prevention practices" in 1998.

- *The surveys should be shortened, combined with others that are conducted periodically by the Departments of Education or Health, or conducted less frequently.*

Administrators and teachers are experiencing greater educational challenges and are being asked to take on additional responsibilities in the education of our youth—often with very limited resources. Any of the above prescriptions should help to secure the continued excellent cooperation of principals and lead health education teachers in providing important information regarding the health education of our youth.

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Iowa Department of Education
Des Moines, Iowa

[Note: The above information was extracted from the *2002 Iowa School Health Education Profile*, prepared for the HIV/AIDS Education Project (Sara Peterson, Project Director), Bureau of Instructional Services, Iowa Department of Education, by Dr. James R. Veale, Statistical/Research Consultant & Educator.]